

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

23522

1. PLACE OF DEATH
72 County New Madrid
Township "
City " (No. ")

Registration District No. 604
Primary Registration District No. 5802

File No. 226
Registered No. _____
St. _____ Ward _____

2. FULL NAME Marie Ozella Shiskey
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan - 1932
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
7 - - - -

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Madrid, Mo

13. NAME Ben Shiskey

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Madrid, Mo

15. MAIDEN NAME Josie Huebeler

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT Ben Shiskey
(ADDRESS) New Madrid

18. BURIAL, CREMATION, OR REMOVAL PLACE Maywood Cem DATE 7-20-32

19. UNDERTAKER Richards and Co
(ADDRESS) New Madrid, Mo

20. FILED 7/20/32 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 19, 1932

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Dead without medical Date of onset _____

Attended (Case "Colitis")

Other contributory causes of importance:
119B / 119 1

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____

(Signed) [Signature] M. D.
(Address) [Address]

MARGIN RESERVED FOR
WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

V. S. No. 2.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 25 1932

